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Holder of License No. **21001**  
For the Practice of Allopathic Medicine  
In the State of Arizona.

(Letter of Reprimand)

## FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
2. Respondent is the holder of License No. 21001 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-03-0018B after receiving notification of a malpractice settlement regarding Respondent's care and treatment of a 71 year-old female patient ("IB").
4. Respondent admitted IB to Verde Valley Hospital ("Hospital") on August 17, 2000. IB was a diabetic who had previously had her right kidney removed as a result of renal failure after acute pyelonephritis many years earlier. IB had recently been treated for rectal bleeding and a subsequent colonoscopy revealed rectal cancer.

1           5.     On August 18, 2000 Respondent performed a low anterior resection of the  
2 rectum with re-anastomosis. Respondent found no evidence of intraperitoneal carcinoma  
3 or liver metastases. During the night of the surgery and for the next day or two IB's urine  
4 output was noted as very low or negligible. IB's BUN and creatinine rose to 18 and 3.2  
5 respectively on the first post-operative day. An ultrasound and CT scan performed on the  
6 first post-operative day were negative for hydronephrosis.

7           6.     On the second post-operative day another CT scan was performed  
8 because of oliguria. This CT scan again showed no evidence of hydronephrosis, but IB's  
9 BUN and creatinine continued to rise. Respondent obtained the services of a urologist  
10 ("Urologist") who performed a cysto and retrograde studies. These studies appear to  
11 represent a hole in the ureter on the left side because there was significant kinking and  
12 the ureter deviated from its normal course at the pelvic rim by going medially to the  
13 midline and the superiorly. There was extravasation of dye from the retrograde study,  
14 however, there was also mention of urine coming from the proximal ureter. As a result  
15 Urologist felt there was a laceration and/or an obstruction of the ureter with an apparent  
16 hole in the ureter. Urologist was unsuccessful on two occasions in attempting to place a  
17 percutaneous nephrostomy.

18           7.     IB was referred from Hospital to Flagstaff where an interventional  
19 radiologist was also unable to do a percutaneous nephrostomy placement. IB developed  
20 pulmonary symptoms, was intubated and then returned to Verde Valley Hospital.  
21 Respondent and nephrologist treated IB intensively and she eventually was taken off the  
22 respirator. Plans were made for IB to undergo dialysis, but after one treatment IB and  
23 her family declined to continue the dialysis. The family was aware that the decision to  
24 forgo dialysis would eventually cause IB's death. IB died on August 31, 2000.

1           8.     In his report, the Board's surgical consultant stressed that Respondent  
2 should have been more aggressive in protecting IB's remaining ureter and noted that the  
3 usual procedure would be to pass a retrograde ureteral catheter and, at the end of the  
4 procedure, to inject methylene blue dye to look for any sign of a rent in the ureter. The  
5 consultant noted that Respondent did identify the single ureter at one point where it  
6 crossed the pelvic brim, but he did otherwise take any steps to protect it.

7           9.     Respondent testified that he did not have a ureteral catheter passed at the  
8 time of surgery. Respondent noted that he generally made that part of his practice when  
9 he did surgery for rectal cancer, many colon cancers, and pelvic surgery, but on the day  
10 of IB's surgery, a urologist was not available to do it. Respondent testified that he felt he  
11 took the appropriate steps at the time of surgery to identify and preserve the ureter.  
12 Respondent noted that after surgery IB did have a small amount of urine output that  
13 dropped off quickly over 24 hours. Respondent testified that he felt that appropriate  
14 studies were done to try and identify whether there was obstruction or acute renal failure.  
15 Respondent noted that he didn't see any sign of hydronephrosis by ultrasound or CT  
16 scan in the first two days after the surgery.

17          10.    Respondent noted that Urologist performed a retrograde examination that  
18 suggested the ureter was blocked. However, the radiologists were never able to perform  
19 a nephrostomy as the kidney never made any urine after that point. Respondent noted  
20 that when it came to the point where it was time to decide whether to undergo dialysis, IB  
21 decided that she did not want it, with the understanding that she had metastatic rectal  
22 cancer, and decided to forgo any other treatment.

23          11.    Respondent was asked whether, after he had noted the ureter at the pelvic  
24 brim at the beginning of surgery, he had done anything else at the completion of the  
25 surgery to assure that there had been no injury. Respondent testified that generally he

1 will look for the ureter anytime instruments or stapling devices are passed to the rectum  
2 before and after the actual resection is done. Respondent noted that at those times  
3 when it is possible to injure or damage the ureter he is generally always in the habit of  
4 checking to identify it and make sure that it is not in the path of the instruments he is  
5 using. Respondent was asked if he did so at the completion of IB's procedure.  
6 Respondent testified that, "I believe we did, yes. I didn't feel that there was any concern  
7 about the possibility of ureteral injury or clip or staple having been placed across the  
8 ureter."

9 12. Respondent testified that he generally does not use dye to check the ureter  
10 even though he usually will pass a stent if he otherwise feels confident that the ureter has  
11 been preserved and, in IB's case, he had no concern about the integrity of the kidney or  
12 the ureter during the surgery. Respondent noted that the percentage of risk for injury to a  
13 ureter during rectal and pelvic surgery is much less than one percent.

14 13. Respondent was asked if he had any idea where the total of 2000 cc's IB  
15 received as a bolus in the 24 hours after surgery was going since she had no urine  
16 output. Respondent testified that the medical records did identify nominal urine output  
17 that dropped off pretty rapidly over the first 12 to 24 hours. Respondent testified that the  
18 first intervention in cases with a post-operative patient such as IB is to give an infusion of  
19 volume or fluid and expect a response. Respondent noted that they had done so, but did  
20 not get an adequate response.

21 14. Respondent was asked to explain his thinking in noting on the first post-  
22 operative day "fear obstruction related to surgery," but not involving Urologist for another  
23 two days. Respondent testified that he believed an obstruction was a possibility and did  
24 proceed with ultrasound and CT scan to evaluate it on the second post-operative day.  
25 Respondent noted that IB's course presented a confusing picture in that if the kidney is

1 working, but the ureter is obstructed, generally you will see signs of hydronephrosis.  
2 However, he did not see any of this, which suggested that IB may have been  
3 experiencing acute renal failure.

4 15. Respondent was asked to explain why, when the first percutaneous  
5 nephrostomy was unsuccessful, he decided to try again the next day as this seems like  
6 an unnecessary delay. Respondent testified that it was really the radiologist's decision  
7 and that he, the radiologist and Urologist discussed the problem amongst themselves.  
8 Respondent noted that in retrospect it was not a good decision because they ended up  
9 spending several more days attempting nephrostomy, including having IB transferred to  
10 another institution to make another attempt at nephrostomy replacement, which was also  
11 unsuccessful.

12 16. Respondent was asked to explain why, on the same day the first attempt  
13 failed when he noted "family is aware of the possible need for exploration," exploration  
14 was not the next step. Respondent testified that it was something that was actively  
15 discussed and it was his feeling that if they could not relieve the obstruction or identify  
16 specifically what had happened that IB should be re-explored, but Urologist felt that it  
17 would be more appropriate in IB's situation to try to relieve any obstruction with a  
18 nephrostomy even though that was ultimately unsuccessful.

19 17. Respondent noted that it was a difficult situation because the patient was  
20 not agreeable to re-exploration, but he had taken the time to do the procedures that were  
21 done in an effort to treat the problem. Respondent testified that he did not know what  
22 happened to the ureter at the time of surgery and why, if it was cut and open, there was  
23 not more evidence of urine leak, or if it was obstructed, why there was not more evidence  
24 of hydronephrosis. Respondent noted that his feeling was by the time they had the  
25 studies done for the first nephrostomy tube attempt that failed probably anything they did

1 to try to retrieve the kidney was going to fail. Respondent testified that, looking back, a  
2 lot of this most likely would have been avoided if he had taken more steps to protect and  
3 assure the ureter was intact at the time of surgery.

4 18. The standard of care required Respondent to protect the single remaining  
5 ureter of a patient who had previously undergone nephrectomy.

6 19. Respondent deviated from the standard of care by not using his normal  
7 method of employing a stent to protect the ureter.

8 20. IB was harmed because she lost the use of her kidney.

9 21. The Board's investigator informed the Board that during the investigation of  
10 this matter Respondent had failed to respond to requests for information.

11 22. In a previous matter heard by the Board immediately preceding this case  
12 Respondent testified as follows: that his responses to the Board's investigation were  
13 lacking, but noted that there was some confusion on his part as there were two  
14 complaints made to the Board at approximately the same time and he entered a consent  
15 agreement regarding one of those complaints; that he thought the requests were  
16 mitigated by the consent agreement, but noted that such a thought did not explain why he  
17 did not contact the Board or return calls from the Board's investigators; that the negative  
18 effect of a previous Letter of Reprimand on his practice may also have contributed to his  
19 anger at the Board and that anger factored into his unresponsiveness to the Board's  
20 requests; and that his failure to respond to the Board was intentional.

#### 21 CONCLUSIONS OF LAW

22 1. The Arizona Medical Board possesses jurisdiction over the subject matter  
23 hereof and over Respondent.  
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25

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(26)(II) ("conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient;") 32-1401(26)(dd) ("failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.")

**ORDER**

Based upon the foregoing Findings of Fact and Conclusions of Law,

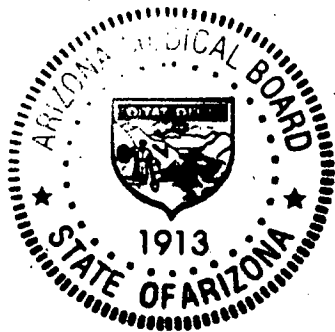
IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for failing to protect the single remaining uterus of a patient who had previously undergone nephrectomy and for failing to cooperate with Board Staff in the process of investigating a complaint.

### RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing or review. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

1 DATED this 16<sup>th</sup> day of APRIL, 2004.



THE ARIZONA MEDICAL BOARD

By Barry A. Cassidy  
BARRY A. CASSIDY, Ph.D., PA-C  
Executive Director

8 ORIGINAL of the foregoing filed this  
9 19<sup>th</sup> day of April, 2004 with:

10 Arizona Medical Board  
11 9545 East Doubletree Ranch Road  
12 Scottsdale, Arizona 85258

13 Executed copy of the foregoing  
14 mailed by U.S. Certified Mail this  
15 19<sup>th</sup> day of April, 2004, to:

16 Malcolm G. Wilkinson, M.D.  
17 Address of Record

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Lia McGraw